**Client Information** **Date**______________

If you previously filled out this form: Any changes since last visit? ☐ **No** ☐ **Yes** *If yes please indicate changes on form.*

**Name** ______________________________________________ **Gender**: M F **Age** _______ **DOB** ______________
**Address** ______________________________________________ **City**_________________**State**_____ **Zip** ________
**Preferred Contact Number** ______________________________ **Email** ______________________________________
May we leave a message if we do not reach you personally? Yes No

**What are your top 3 concerns at this time?**
1. ___________________________________________________________
2. ___________________________________________________________
3. ___________________________________________________________

**Medical History**:

Pregnant? Yes No Maybe N/A Breastfeeding? Yes No N/A
Do you smoke? Yes No
Health Conditions: _____________________________________________________
Past Surgeries: _______________________________________________________
Have you ever been diagnosed with Cancer? ☐ **No** ☐ **Yes** *(date of last treatment)*__________
Current Medications: ___________________________________________________
Prescription Topicals: __________________________________________________
Allergies (include aspirin & iodine): _________________________________________

**Previous Treatments:**

| | | | | |
|---|---|---|---|---|
| Facials | Yes | No | Last treatment:__________ | Any complications?__________________________ |
| Microdermabrasion | Yes | No | Last treatment:__________ | Any complications?__________________________ |
| Chemical Peels | Yes | No | Last treatment:__________ | Any complications?__________________________ |
| Waxing | Yes | No | Last treatment:__________ | Any complications?__________________________ |
| Tanning | Yes | No | Last treatment:__________ | Any complications?__________________________ |
| Laser Therapy | Yes | No | Last treatment:__________ | Any complications?__________________________ |
| Massage | Yes | No | Last treatment:__________ | Any complications?__________________________ |

**Skin Conditions:** *(please circle the items below that pertain to you)*

| | | | |
|---|---|---|---|
| Skin Infection | Herpes (cold sores) | Keloids/Excessive Scarring | Sun Sensitivity |
| Skin Cancer | Poor Healing | Tattoos/Permanent Makeup | Easy Bruising |
| Eczema | Psoriasis | Lymph Nodes Removed | Diabetes |

**Skincare:** What type of skin do you feel you have? Dry Oily Normal Combination
What is your skin routine? *(Indicate any cleansers, toners, serums, moisturizers, masques, etc.)*

1.____________________________________
2.____________________________________
3.____________________________________
4.____________________________________
5.____________________________________
6.____________________________________

**Osmosis Treatment Consent** **Date**______________

Client Name ____________________________________________________________

**Please Initial:**

_________ I agree that the nature and purpose of the treatment has been explained to me and any questions I have regarding the treatment have been explained to my satisfaction.

_________ I understand that with any treatment certain risks are involved and that any complications from known or unknown causes could occur.

_________ I understand that possible side effects include, but are not limited to: mild to moderate redness, mild to moderate peeling or flaking, stinging, dry skin, tenderness, pimples, cold sores or allergic reactions. Most side effects are temporary and will dissipate within 3-7 days.

_________ I do not have active cold sores.

_________ I will call to inform my skincare professional of any complications or concerns I may have as soon as they occur.

_________ I understand that it is recommended prior to having a facial infusion to not have used Retin A for 72 hours, Accutane in 6 months or have waxed 24 hours prior to receiving treatment.

______________________________________________________________________________

CLIENT SIGNATURE PRINT NAME DATE

**Technician Notes:**

Treatment Receiving Today (check one):

☐ Medi-Facial ☐ Holistic Calming Facial

______________________________________________________________________________

☐ Facial Infusion ☐ Holistic Stimulating Facial

______________________________________________________________________________

☐ Medi-Infusion ☐ RevitaPen Facial

______________________________________________________________________________

Notes:

I have reviewed the treatment and post care instructions to the client stated above and answered any questions.

______________________________________________________________________________

TECHNICIAN SIGNATURE DATE